what the report or decision was of -- of the medical department?

A I do not. And -- and there was really no change to my knowledge by the time I left in how coverage was provided, and there was no virtual ICU. So if there was a decision, I don't know what eventuated after that decision.

Q Okay. After the presentation, did you have any meetings with Dr. Weiss regarding any comments or statements made during the presentation?

A Yes. We -- he told me that he presented the information, whatever the --

Q Uh-huh.

A -- information was we discussed about increasing coverage at the department of medicine meeting.

Q Right. Did -- did he tell you what some of the members said?

A I just got a sense, without him identifying the individuals, that was not a well-received proposition.

Q Okay. Did that concern you?

A Yes.

Q Okay. And why do you say that concerns

you?
A Because I agreed with Dr. Weiss in our conversations that it would be a very laudable goal to increase attending coverage in some form or fashion in the ICU.
Q Okay. Can you think of any reason why doctor -- why Mount Carmel wouldn't follow Dr. Weiss's recommendation?
MR. ARMSTRONG: Objection to the relevance and speculation.
THE WITNESS: I could speculate. There's a --
BY MR. PATMON:
Q Sure.
A It's sometimes impossible to follow recommendations because you can say, "I'll recruit an ICU specialist. I'll budget the money for an ICU specialist," and there may not be one to recruit.
I've been in other communities, Canton, Ohio, where we would have senior intensive care unit fellows from The Cleveland Clinic come to Canton and watch the unit at night, and there were no fellows available because the fellows at Ohio State University already had a --

A Yes.
Q Okay. Do you have an understanding of that statement?
A Yes.
Q Okay. What's your understanding of that statement?
A They're just saying that night float was designed because of the duty hour limits.
Q Right.
A And its design is not conducive in educational -- from an educational perspective with good education. And, additionally, it may not be conducive to safety and patient care because you're switching doctors multiple times. You have a daytime, a nighttime, and stuff like that. So they're saying they have questions about night float because, even though it has to occur, it may not be the best thing for education or patient care.
Q Right. And one of the reason they're articulating is lack of direct supervision; right?
A Correct. Because there's -- the residents do not have an attending physician in-house usually when they're doing a night float. They have them available by phone.

direct supervision. So you understood -- did you --

MR. PATMON: Can you read back my question? Now I've forgotten.

(Question read.)

BY MR. PATMON:

Q Do you understand that? When they say, "lack of direct supervision," what they're saying is --

A I understand what they mean. Yes.

Q Okay. What do they mean?

A The resident, in a typical night float, is where the buck stops. That resident does not have a more senior physician usually in the hospital. If that resident wants further advice on a medically complex issue, they have to attain it by phone rather than with the person being there right to assist them.

Q Okay. And that situation would apply if a night float resident were treating patients in ICU also; correct?

A Correct.

Q All right. We're going to be done with this in just a second. Turn to page 59 of that document.